# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

09900

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 32

**1. PLACE OF DEATH:**
County Calvert
City or town Owings
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County Calvert
City or town Chaney
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Russell Armiger — **3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | S |

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1919

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 26 | 1 mo | — | ..... hrs. ..... min. |

9. Birthplace Md (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Elisha Armiger
13. Birthplace Md
MOTHER 14. Maiden name Nellie R. Brady
15. Birthplace Md
16. Informant Eliel W. Armiger
Address Chaney, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 22 45 (month) (day) (year)
Cemetery or crematory Smithville Cemetery
Location Dunkirk, Md.
18. Funeral director W. H. Hutchins
Address Owings, Md.
19. Oct 20 1945 (Date rec'd by registrar) Grace L. Hutchins Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20 1945, at 1205 M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw h ..... alive on ..... 19 .....

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | 1 hr. |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. W. Ward Dept. Med. Examiner M. D. or other
Address Upper Marlboro, Md. Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

09901

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 52

**1. PLACE OF DEATH:**
County: Calvert
City or town: Prince Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 hrs.
Hospital, institution, or street address where death occurred: Prince Frederick Hospital
How long in hospital or institution? 12 hrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Calvert
City or town: Sunderland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Thomas Heighe Blake

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M. | W | Married |

6.(b) Name of husband or wife: Josephine Penbrooke
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 4, 1872

| 8. AGE: Years | Months | Days | If less than one day: hrs. | min. |
|---|---|---|---|---|
| 93 | 2 | — | | |

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Joseph Blake
13. Birthplace: Md.

MOTHER
14. Maiden name: Elizabeth Blake
15. Birthplace: Md

16. Informant: Penbrooke Blake
Address: Sunderland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 22 45 (mouth) (day) (year)
Cemetery or crematory: All Saints Cemetery
Location: Sunderland, Md.

18. Funeral director: W. H. Hutchins
Address: Owings, Md.

19. Oct 20 19 45 (Date rec'd by registrar) Grace L. Hutchins Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20 19 45, at 12:00 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 19 19 45, to 19
and that I last saw h alive on October 19 19 45

Immediate cause of death: Acute cardiac failure due to hypertension

Due to: Cardiovascular disease

Due to: myocardial degeneration

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

| DURATION |
|---|
| |
| |
| |
| |
| |
| |

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Page [illegible]
M. D. or other
Address: Prince Frederick Date signed: 10-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

09902

## CERTIFICATE OF DEATH

Reg. Diat. No. 51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A-13

**1. PLACE OF DEATH:**

County: Calvert

City or town: Mars

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md County: Calvert

City or town: Mars.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Martha Brown.

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | C | widow |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1-15-1891

8. AGE: Years: 64 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: md (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER — 12. Name: Raymon Thomas

13. Birthplace: md.

MOTHER — 14. Maiden name: Eliza Lake.

15. Birthplace: Md.

16. Informant: Wilson Parran

Address: Mars, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-9-45 (month) (day) (year)

Cemetery or crematory: Plum Point

Location: Calvert

18. Funeral director: R. E. Sewell

Address: Ga. Frederick, Md.

19. 10/8 19 45 L. N. Craig

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/6, 1945, at 5:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Oct 1945 to 6 Oct 1945

and that I last saw her alive on 5 Oct 1945

| Immediate cause of death | DURATION |
|---|---|
| Hypertension, syphilis - Hemiplegia and dementia | |
| Due to: arteriosclerosis | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Hughesville, Md. Date signed: 7 Oct 45

09903

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (179-B)

## CERTIFICATE OF DEATH

★ Reg. Diat. No. 50

**1. PLACE OF DEATH:**
County: Calvert
City or town: MINE WARFARE TEST STATION, SOLOMONS, MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 min.
Hospital, institution, or street address where death occurred:
Dispensary Mine Warfare Test Station, Solomons, Md.
How long in hospital or institution? 65 min.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: U.S. NAVY County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

**3. (a) FULL NAME:** FITZMAURICE, James Joseph

**3. (b) Social Security Number:** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife: not married
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 10-29-19

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 25 | 11 | 20 | hrs. min. |

9. Birthplace: Conn.
(Town, county, and state)
10. Usual occupation: U.S. NAVY
11. Industry or business: U.S. NAVY

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mrs. E. FITZMAURICE
15. Birthplace: Unknown

16. Informant
Address

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Oct 25, 1945
(month) (day) (year)

Cemetery or crematory
Location: Norwich, Connecticut
18. Funeral director: [illegible] Funeral Hall
Address: 351 Main St. Norwich - Conn.

19. 45 Oct 23 1945
(Date rec'd by registrar)
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-19-45 19 at 1115 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1007 10-19-45 19 to 1115 10-19-45 19
and that I last saw h im alive on 10-19-45. 19

| Immediate cause of death | DURATION |
|---|---|
| Unknown | |
| Pending Autopsy findings: Toxic encepha- | |
| lopathy, compatible with barbiturate poisoning, Neonal | |
| Due to: Unknown present in the entire brain. | |
| Lungs: Congestion and hemorrhage. | |
| Due to: Kidneys: Interstitial edema. c.w.s. | |
| | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results: Naval Hospital Bethesda, Md.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J.T. SMITH Lieut.Comdr., (MC) USN
By direction B. G. CLARKE, Lieut(MC)USNR
Address: USN Mine Warfare Test Station, SOLOMONS, MD.
Date signed: 10-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore (83-a)

09904

## CERTIFICATE OF DEATH

Reg. Diat. No. 51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Calvert
City or town: Willows
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md County: Calvert
City or town: willows
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME:** Roberta L. Freeland

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | C | Single |

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): aug 19, 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | | | hrs. ..... min. |

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: William Freeland
13. Birthplace: md

MOTHER
14. Maiden name: Alice Reid
15. Birthplace: md

16. Informant: Edyth Berry
Address: Lusby, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-20-45 (month) (day) (year)
Cemetery or crematory: Plum Point
Location: Calvert,

18. Funeral director: P.E. Sewell.
Address: Prince Frederick.

19. 10-18 1945 (Date rec'd by registrar) L.N. King Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-17, 1945, at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Sept 1945, to 17 Oct 1945 and that I last saw h[illegible] alive on 16 Oct 1945

| Immediate cause of death | DURATION |
|---|---|
| Cerebral accident. | |
| Due to Hypertension | |
| Due to arteriosclerosis | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings at operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R.L. Hagerstown M. D. or other
Address: Hagerstown Date signed 18 Oct 45

09905

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73d

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 60

**1. PLACE OF DEATH:**
County Calvert
City or town Dowell
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State md County Calvert
City or town Dowell,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** James H Garner.

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M. | C. | X |

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 8, 1854

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 91 | | | ..... hrs. ..... min. |

9. Birthplace md (Town, county, and state)
10. Usual occupation Laborer.
11. Industry or business

FATHER
12. Name George Garner.
13. Birthplace md

MOTHER
14. Maiden name Mary Burns.
15. Birthplace md

16. Informant John Garner
Address Dowell, md

17. Burial Date thereof 10-24, 45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Johns.
Location Calvert

18. Funeral director P. E. Sewell.
Address Prince Frederick, md

19. Oct 29 — 1945 N. J. Parker
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27-1945, at 4.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to Oct 27 1945
and that I last saw h..... alive on ..... 19 45

| Immediate cause of death | DURATION |
|---|---|
| Heart failure | |
| Due to Hypertensive c. v. d. | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Roberts de Villarreal M.D. or other
Address Prince Frederick, Md Date signed 10/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for the change of age is shown on FILM No. G 98 OCT 26 1945

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

09906

## CERTIFICATE OF DEATH

★ Reg. Diat. No. 5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Calvert
City or town: Island Creek
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md County: Calvert
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Ida S. Gray.

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | C. | widow. |

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Md. Dec 29, 1864.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 9 | 6 | ..... hrs. ..... min. |

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Not known
13. Birthplace

MOTHER
14. Maiden name: Charlotte Murray.
15. Birthplace: Md

16. Informant: Elizabeth Brooks.
Address: 2511 McCulloh St. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-7-45 (month) (day) (year)
Cemetery or crematory: Island Creek, Md
Location: Calvert.

18. Funeral director: R.E. Sewell.
Address: Prince Frederick, Md.

19. 10/5 1945 (Date rec'd by registrar) L. N. King Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-5 19 45 at 10 P.M. aw

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19.... and that I last saw h... alive on Oct ✓ 19 45

| Immediate cause of death | DURATION |
|---|---|
| Acidosis | |
| Due to: Acute nephritis | |
| Due to: - Nephro-sclerosis | |
| Other conditions: Generalized arterio-sclerosis | |

(Incindo pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Roberts & Villaret Injured at work?

23. SIGNATURE: R.E. Sewell M. D. or other
Address: Prince Frederick Date signed 10/6/45

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-A)

## CERTIFICATE OF DEATH

Reg. Diat. No. 5708

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Calvert

City or town: Lusby

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Calvert

City or town: Lusby

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** Sydney Johnson Gross

**3. (b) Social Security Number:** 0

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Black | Married |

6.(b) Name of husband or wife: John Frank Gross

6.(c) If alive, give age: 83 years

7. Birth date of deceased (mo., day, yr.): 1867

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | - | - | hrs. min. |

9. Birthplace: Lusby, Calvert County, Md.
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER — 12. Name: John Johnson

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Jane Bishop

MOTHER — 15. Birthplace: Maryland

16. Informant: John Frank Gross

Address: Lusby, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof OCT. 3-45 (month) (day) (year)

Cemetery or crematory: St. Johns

Location: Lusby, Maryland

18. Funeral director: C. Sewell

Address: Prince Frederick, Md.

19. 10/1/45 (Date rec'd by registrar) 19.. D.E.S. Coster Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1 — 1945 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 — 19.. to Aug. 31 — 1945 and that I last saw her alive on Aug 31 — 1945

| Immediate cause of death | DURATION |
|---|---|
| arteriosclerosis — | 5 Yrs |
| Due to Cardiac Degeneration | 6 mos |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. S. Coster M.D.
M. D. or other

Address: Solomons, Md. Date signed 10/1/45

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-m)

# CERTIFICATE OF DEATH

09908

★ Reg. Diat. No. 57

**1. PLACE OF DEATH:**

County Calvert

City or town Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Calvert County Hospital

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md County Calvert

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Baby Girl Hamilton

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | S |

B.(b) Name of husband or wife

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1945

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 0 | 0 | 3 hrs. 15 min. |

9. Birthplace Calvert Co., Hospital, Md (Town, county, and state)

10. Usual occupation Baby

11. Industry or business

FATHER 12. Name M. W. Hamilton

13. Birthplace Oklahoma

MOTHER 14. Maiden name Elizabeth Buckmaster

15. Birthplace Calvert Co., Md

16. Informant M. W. Hamilton

Address North Beach

17. Burial (Burial, cremation, or removal, Which?) Date thereof Oct. 25, 1945 (month) (day) (year)

Cemetery or ~~crematory~~ Christ Church

Location Port Republic, Md

18. Funeral director A. A. Harkins & Son

Address Mutual, Md

19. 10/25/45 (Date rec'd by registrar) L. N. King Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1945, at 7:58 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h[illegible] alive on 5:25 pm 1945

| Immediate cause of death | DURATION |
|---|---|
| Malformation of abdomen | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death shenld be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. D. Dillard M. D. or other

Address Prince Fred. Date signed Oct. 25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

09909

2411 N. Charles St., Baltimore 83(a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Calvert

City or town: Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: md County: Calvert

City or town: Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Rachel A Hicks

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | C | X |

6.(b) Name of husband or wife: Elijah Hicks

6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): ~~1869~~ nov 4, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | | | ....hrs. ....min. |

9. Birthplace: md (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Housewife

FATHER 12. Name: John Gordy

13. Birthplace: md

MOTHER 14. Maiden name: Louise Gant

15. Birthplace: md.

16. Informant: Elijah Hicks

Address: Prince Frederick

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-21-45 (month) (day) (year)

Cemetery or crematory: Palmeant Church

Location: Calvert

18. Funeral director: P.E. Sewell

Address: Prince Frederick md

19. ....19.... (Date rec'd by registrar) ....Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17 1945, at ....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 11th 1945, to Oct 17 1945 and that I last saw her alive on Oct 16 1945

| Immediate cause of death | Cerebral Hemmorhage | DURATION |
|---|---|---|
| | | |
| Due to | Hypertension | |
| Due to | | |
| Due to | | |
| Other conditions | | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Prince Frederick Date signed: Oct 20th 1945

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

09910

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 52

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Calvert
City or town Chesapeake
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County Calvert
City or town Owings Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Joseph William King

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | W |

6.(b) Name of husband or wife Cora W. King
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | | | hrs. min. |

9. Birthplace (Town, county, and state)
10. Usual occupation farmer
11. Industry or business

FATHER
12. Name Thomas King
13. Birthplace Md.

MOTHER
14. Maiden name unknown
15. Birthplace

16. Informant Lawrence King
Address Lothian Md.

17. Burial Date thereof 10/28/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cemetery
Location Mt Harmony
18. Funeral director Wm. H. Hutchins
Address Owings Md.

19. Oct. 27 1945 Wm Hutchins Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1945 at 8.20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1942 to Oct 26 1945
and that I last saw h alive on Oct 26 1945

| Immediate cause of death | DURATION |
|---|---|
| arteriosclerosis | 5 yrs |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H M Ward M. D. or other
Address Owings Md Date signed 10/27/45

Evidence for the change of age is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

09911

FILM No. G 98 OCT 23 1945

## CERTIFICATE OF DEATH

★ Reg. Diat. No. 51

**1. PLACE OF DEATH:**

County: Calvert

City or town: Chaney Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md County: Calvert

City or town: Chaney

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** William Machall

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M. | C | X |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1881

8. AGE: Years: 63 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business

FATHER — 12. Name: John Machall

13. Birthplace: Md

MOTHER — 14. Maiden name: Martha Cook

15. Birthplace: Md

16. Informant: Erkhart Machall

Address: Chaneyville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-13-45 (month) (day) (year)

Cemetery or crematory: Hall's Cemet.

Location: Calvert.

18. Funeral director: C. E. Sewell

Address: Ox. Frederick Md.

19. 10/11 19 45 (Date rec'd by registrar) L. N. King Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-11 19 45, at 20 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/4 19 45, to 19

and that I last saw h alive on 10/4 19 45

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Frmt Frederick Date signed 10/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (442)

## CERTIFICATE OF DEATH

09912

Reg. Diat. No. 57

**1. PLACE OF DEATH:**
County: Calvert
City or town: Bruce Frederick Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? 2 Days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Calvert
City or town: Huntingtown, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

**3.(a) FULL NAME:** Sarah Elizabeth Thacker.

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | |

6.(b) Name of husband or wife: Landon Thacker.
6.(c) If alive, give age: 39 years
7. Birth date of deceased (mo., day, yr.): Aug. 14, 1908

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | — | — | — hrs. — min. |

9. Birthplace: Penn. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home.
FATHER 12. Name: James. Bantter
13. Birthplace: Penn.
MOTHER 14. Maiden name: Mary Fowler.
15. Birthplace: Penn.
16. Informant: Landon Thacker
Address: Huntingtown Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 6, 1945 (month) (day) (year)
Cemetery or crematory: Piney Grove
Location: Piney Grove
18. Funeral director: J. A. Hutchinson & Son
Address: Mutual, Md
19. 10/V- 1945 (Date rec'd by registrar) L. N. King Registrar

## MEDICAL CERTIFICATION.

20. DATE OF DEATH: 5 Oct. 1945, at 2 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 March 1945, to 5 Oct 1945 and that I last saw h.. alive on 5 Oct 1945

| Immediate cause of death | DURATION |
|---|---|
| Toxemia of Pregnancy | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Huntingtown Date signed 5 Oct 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15